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August 16, 2004

Secretary S. Kimberly Belshe
California Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95822

August 16, 2004

Re: Request for Comments to the Recommendations of the California Performance Review

Dear Secretary Belshe,

Thank you for inviting the Western Center on Law and Poverty to provide the Schwarzenegger Administration with our preliminary comments on the recommendations of the California Performance Review. We appreciate the Administration's efforts to take a fresh look at the way that California delivers services to its' citizens. While the scope of the proposals, the lack of details and the short time frame for response limit the depth of our analysis, we hope that our comments will assist you in prioritizing which recommendations should be pursued in the weeks and month ahead.

As a general matter the recommendations in the health and human service area represent a profound shift in the way that the state delivers services to low-income persons. It would appear to shift policy authority to the Agency level and away from individual departments. It would combine many separate programs into single "Centers" even where previous experience has shown that a separately identified entity and focused administrative attention was required to improve services. It would put MediCal, CalWORKs and Food Stamp eligibility determinations into the hands of the state. This proposal raises serious issues about public access, transparency and accountability. Where would the public go to have their concerns addressed? What power would the proposed "Centers" have over matters currently within departmental discretion? Would all policy determinations be resolved at the Agency level?

The sheer magnitude of the proposals just in the health and human service area would require a massive undertaking to accomplish. Implementing even one of the 33 issues will require a significant investment of time and political will. The notion that the state or advocates could work on all 33 issues is unrealistic. Agency and department resources would have to be shifted to managing the consolidations proposed for health and human

services. This could jeopardize the efficient administration of programs and cause the state to miss other opportunities to expand or improve services. We urge the Administration to prioritize the recommendations so that the state, advocacy organizations and the public can more effectively participate in achievable endeavors.

Not surprisingly for a report this ambitious, it lacks crucial detail necessary to properly evaluate the proposals. A proposal as seemingly benign (and potentially positive) as establishing consistent eligibility for MediCal, Food Stamps and CalWORKs is, in fact, an extremely complicated matter. At minimum, it would require agreement on, and legislative or administrative approval for, many federal and state law changes. Some legal changes may significantly impact existing or potential judicial remedies and could require court approval. An extensive new state regulatory process would follow the legal changes. The changes would require major negotiations with state and county employee unions. It would require significant investment in information technology and workforce training. We estimate that working through the myriad details of these changes would require a minimum of three to five years before implementation could occur.

The recommendations tend to focus on streamlining government operations as a way to reduce General Fund costs. While this approach may have merit, we believe that other opportunities for efficiencies exist. For example, the report fails to look at revenue enhancements and ways to draw down more federal dollars, including numerous examples advocates laid out in presentations and memos during the Medi-Cal Redesign. Western Center can provide more detail on revenue options if requested.

The recommendations also do not explore the potential savings from a more holistic approach to providing services. Persons in need of government services often need more than one service. Yet most funding and programs only provide assistance for a specific need. Thus a person who applies for Medi-Cal is often not evaluated for other service needs. Worse yet, most programs do not communicate with each other and may provide services that are incompatible with other services offered. The result is that persons in need can end up in crisis, even though they have received some services because other key services were omitted. While some contend that the state saves money by sharply rationing services, there is increasing evidence that not providing services actually costs the state money. Governor Davis' Homeless Task Force report and HHS' own *Olmstead* plan are both replete with such examples. Western Center strongly encourages the Administration to investigate ways to reduce state costs by developing more comprehensive approaches to assisting low-income families.

The report at several places recommends that some current state and county operations be contracted out to private vendors. Western Center is concerned that this approach may undermine the delivery of services if not carefully considered. We are particularly concerned that the degree to which private firms take on state work may have the unintended effect of increasing errors and miscommunication. In many instances the accessibility of knowledgeable and experienced government program staff are instrumental in assisting low-income applicants who might not otherwise be able to navigate the system.

Attached are our comments for the following specific proposals:

- **Government Must Reorganize Chapter 2 – The Department of Health and Human Services**
  B. Center for Health Purchasing
  D. Center for Quality Assurance
  G. Center for Social Services

- **HHS01 Transform Eligibility Processing**

- **HHS02 Realigning the Administration of Health and Human Service Programs**

- **HHS10 Align State Law Regarding the $50 Child Support Disregard Payments**

- **HHS23 Streamline Oversight Requirements for Conducting Medical Survey/Audits of Health Plans**

- **HHS26 Maximize Federal Funding by Shifting Medi-Cal Costs to Medicare**

- **HHS27 Automate Identification of Other Health Coverage for Medi-Cal Beneficiaries**

- **HHS30 Centralize Medi-Cal Treatment Authorization Process**

- **HHS33 Eliminate Dual Capitation for Medicare/ Medi-Cal Managed Care Plans**

Western Center looks forward to the opportunity to work with the Administration as the issues are prioritized and more detail is provided.

Sincerely,

Michael Herald
Legislative Advocate, Social Services

Angela Gilliard
Legislative Advocate, Health

CHAPTER 2 – THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

CPR Reorganization Recommendations/Western Center Comments

The Health and Human Services Agency and its constituent departments should be reorganized into one integrated Department with centers focused around core functions. By doing this, the Department should be able to eliminate duplication and provide better service delivery in each Center. The Secretary of the Health and Human Services Department should be responsible for coordinating all of the activities within the Department and providing the overall strategic leadership.

B. Center for Health Purchasing

1. **Management Goal:** This Center should maintain and improve the system of health care and insurance support for Californians. This Center should be committed to maximizing California's purchasing power to achieve the "best price" and the "best service" in the delivery of health services.

2. **Proposed Functions:** This Center should bring together health delivery and health purchasing programs into one organization. This consolidation should maximize the depth of experience in healthcare programs and should allow for the exchange of best practices among the healthcare and health insurance programs.

3. **Transferred Functions:** The California Medical Assistance Commission should be abolished and its functions should be transferred to the Secretary of Health and Human Services. Functions that should be included in this Center are the existing health delivery and insurance programs in the current Health and Human Services Agency, including: Medi-Cal, California Children's Services, Child Health and Disability Prevention, Genetically Handicapped Persons, County Medical Services and In-Home Support Services Programs. The Managed Risk Medical Insurance Program, the Access for Infants and Mothers Program and the Healthy Families Program, which are currently part of the Managed Risk Medical Insurance Board, should also be transferred to this center.

Western Center Comments on Recommendations on the Organization/Structure of Government

1. **Will the reorganization proposal improve service delivery and outcomes for clients?**

   Western Center on Law and Poverty does see conceptual logic to a proposal to consolidate purchasing of medical services. However, in practical application and based on historical activity, we do not believe it will result in improved service delivery and outcomes for clients. For instance, MRMIB has traditionally been able to implement new programs, adopt regulations and adjust to new requirements much more expeditiously than DHS. While we may not have agreed with every action or decision, we have found MRMIB to be more responsive and the decision making process to be more accessible than the massive bureaucracy of a combine department such as DHS. The same is true of CMAC. We believe that the evidence will show that

CMAC has successfully saved billions of dollars and has negotiated hospital contracts more efficiently than if it had been done through a multi-layered bureaucracy as proposed here.

MRMIB has proposed and adopted more sets of regulations in four years than DHS has in ten years. We are still waiting for DHS to develop a notice to Medi-Cal managed care beneficiaries as required by SB 59 in the HMO reform act of 1999. The MRMIB web site is far more user friendly than anything DHS has ever done. DHS takes 6 months to certify Medi-Cal providers. DHS was not able to procure a contract for HEDIS ® measures for 2003 in a timely fashion. MRMIB does not have the same problem types of delays.

2. **Will the proposal promote better coordination and integration of policy and programs for specific client groups?**
   It may marginally improve coordination and integration by consolidating in this fashion, but we think any possible improvements are outweighed by the negative impacts such as the inertia that will be added by the new layers of decision making.

3. **Does the proposal provide better accountability for specific client groups?**
   The proposal will definitely not provide better accountability for hospitals than a separate CMAC. It is hard to assess with regard to some of the other programs. Some of them couldn't get much worse.

4. **What are the strongest reasons for implementing this recommendation? What are the greatest potential concerns?**
   As stated above, consolidation of programs that provide, oversee and purchase health care services has a superficial logic. It arguably would have economies of scale and would add to the leverage and purchasing power of each program. Nonetheless, on balance, our experience with state departments tells us that consolidation leads to less accountability, loss of innovativeness, and insulates the program from the decision-makers as well as clients and advocates.

D. Center for Quality Assurance

1. **Management Goal:** The goal of this Center should be to provide licensing and oversight for businesses and consumers for health and human services. Consolidation should provide a consistent approach to the regulation of health care and human services in California.

2. **Proposed Functions:** The Center for Quality Assurance should consolidate the licensing activities for health facilities, community care facilities and health professions into one organization.

3. **Transferred Functions:** The current licensing functions from all departments in the current Health and Human Services Agency should be transferred into this Center. These activities include health facilities licensing from the Department of Health Services and community care licensing from the Department of Social Services. The authority of the health professions licensing boards currently part of the Department

of Consumer Affairs should be transferred from the State and Consumer Services Agency. Authority for the programs in the Department of Managed Health Care should be transferred to this Center from the Business, Transportation and Housing Agency.

Western Center Comments on Recommendations on the Organization/Structure of Government

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**
   In principal, the concept of consolidating the licensing of health care related entities has merit. However, there are aspects to this particular proposal that are of grave concern to Western Center on Law and Poverty. In particular, the entity that has responsibility for licensing HMOs must remain a separately identified department or the state will be repeating the mistakes that led us to the revolution known as the HMO Reform of 1999.

   One of the major sources of consumer dissatisfaction was that there was not a widely publicized and clearly identified place to go for assistance with HMO related problems. The regulator was remote and unresponsive. It is hard to imagine that the HMO Help Center, for instance, would be improved if it were swallowed up in some Center at HHS.

2. **Will the proposal improve delivery of services?**
   The new DMHC has constituted itself in a remarkably short period time and has almost completely implemented the reforms mandated by the HMO Reform Act of 1999. By comparison the Department of Health Services has yet to implement the one requirement of a standardized notice to Medi-Cal managed care HMO enrollees for which it was responsible. All too frequently, the legislators and advocates are told by DHS that a mandated report or regulation is under review up the chain of authority. Placing these levels of supervision over DMHC will not improve the delivery of services.

   In addition, DMHC has developed a model web site. It is user friendly, current and full of valuable information. Their business is conducted with a level of transparency that is unusual in state government and should be emulated by others. This is not likely to be continued if it is lost in some center at HHS. This transparency and consumer accessibility is not the current or traditional practice or philosophy of HHS or any of its member agencies nor is there anything in the report to indicate a proposed change in focus.

3. **Will the proposal improve outcomes?**

As stated above, the DMHC produces regulations and takes other appropriate actions in record time as compared to other HHS type departments. These other departments should look to DMHC as to how to improve outcomes. It is very unlikely that requiring it to be absorbed into these other departments will improve outcomes. This proposed consolidation would also allow for diversion of staff and resources when times were tough. Now the sole mission of the DMHC is regulation of HMOs with an emphasis on assisting consumers. The more the distinction of a separate department is blurred, the easier it would be to shift priorities.

While we don't always agree with the actions and policies taken by DMHC, there is a high level of trust, accessibility and transparency. This is not true for larger departments with multiple levels of administrators and a large variety of responsibilities.

4. **What will be the impact on the service provider network?**
The impact is likely to be a less responsive and more remote regulator. The senior staff of the existing department is very available and visible. The service providers know how to find the department. They have ongoing meetings and relationships.

5. **Will the proposal improve program efficiency?**

We have been representing Medi-Cal and other low-income residents of California for almost 40 years. Based on our experience with departments ranging from DMHC to DHS and the old Department of Corporations, we feel confident in asserting that DMHC is a model of responsiveness and efficiency compared to other departments and that moving into a larger bureaucracy will completely undermine the current mission.

Western Center has been advocating for HMO reform since 1997. The development of a separate and extremely visible regulator was a key component of the 1999 HMO reform legislation. To reverse that will be a huge step backward for consumers and public protection in California. It will send a message that the state is no longer the in the business of protecting its HMO enrollees.

G. Center for Social Services

1. **Management Goal:** The goal of this Center should be to oversee the delivery of benefits and services that foster self-sufficiency, dignity and well-being in the lives of Californians.

2. **Proposed Functions:** The Center for Social Services should consolidate the state's income support programs including child support, community development programs and social services programs for children, families and aging individuals. This Center should also be responsible for the entire spectrum of support services

for children and California's aging population; it should also incorporate planning the continuum of care for both of these population groups.

3. **Transferred Functions:** This Center should include the main programs of the Departments of Social Services, Aging, Community Services and Child Support Services. The programs in this Center should include: CalWORKs, Child Welfare Services, Child Support, Food Stamps, Supplemental Security Income, Services to the Aging and low-income energy grants.

Western Center Comments on Recommendations on the Organization/Structure of Government

1. Will the reorganization proposal improve service delivery and outcomes for clients?

There is little in the report to suggest major changes in outcomes for low-income persons who use the Department's services. Shifting policy responsibility and outcome accountability to the Secretary's level is likely to be a mixed result. On one hand shifting all policy decisions to the Secretary should increase consistency throughout programs. But eliminating the significant policy roles of departments may reduce specific program expertise and homogenize the end product.

The changes also consolidate similar programs and functions into a smaller group of "Centers." It is unclear what authority the Centers will have in comparison to the current authority of the department where the programs are currently located. The prospect of bureaucratic delay will increase the more policy decisions are moved to a higher level. Consolidating programs into "Centers" is likely to be highly time consuming and detract from accomplishment of existing and future workloads. Many HHS agencies have already experienced significant staff losses, particularly among experienced managers. Adding substantial new duties over a long period of time will decrease morale among the employees left to carry out the combined tasks.

2. Will the proposal promote better coordination and integration of policy and programs for specific client groups?

The proposal to consolidate various programs into the "Center for Social Services" would significantly expand the duties of the current Department of Social Services. Some departments were created for the specific purpose of accomplishing an important objective. Often these departments were created because other departments were unable to provide the expertise and attention needed. My merging departments together, some programs may not receive the attention needed to make them effective.

Integration of programs is a major problem for program recipients. Many recipients are not aware of the programs available to them and miss out on key services that would enhance their outcomes. Unfortunately, most HHS programs are "siloed", that is, they provide a specific population with a particular service. For example, a developmentally disabled person can have their housing and services covered by MediCal while in state care but if they choose to live independently, MediCal will not pay for the housing because it is not a "health facility." Merely, placing similar programs in a particular "Center" will not integrate programs if they have different eligibility rules.

Most notable is that the CPR report does not recommend consolidating the job training and education components of CalWORKs into the proposed Department of Education and Workforce Preparation. The new department would be responsible for aligning the state's crazy quilt pattern of training and education under one department. Many of these programs are already actively involved in providing education and training to CalWORKs recipients. While we have no opinion on the merits of the education and training proposal, to the degree it makes sense to consolidate these functions, it is important to make sure that low income recipients also benefit from these changes.

3. Does the proposal provide better accountability for specific client groups?

The consolidation may make it more difficult for program participants, advocates and the Legislature to access key decision makers. The Secretary will now be involved in many more policy decisions, reducing the attention paid to issues that formerly received significant attention at departments.

4. What are the strongest reasons for implementing this recommendation? What are the greatest potential concerns?

The strongest reason to pursue this would be if it would significantly increase the number of low-income person receiving assistance. That is not clear from moving agencies around.

The greatest concern is that the state attempts too bold an effort and is unable to advance proposals that have merit and are achievable.

CHAPTER 2 – THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

CPR Policy Recommendations/Western Center Responses

HHS01 Transform Eligibility Processing

Proposal Section HHS01 purports to save administrative funds by increasing coordination and eliminating duplication between three different public benefits programs (Medi-Cal, CalWORKs, and Food Stamps) using the Healthy Families model. While this is a goal that could help our low-income clients if implemented thoughtfully and carefully, we have significant concerns about the mechanisms proposed and the unintended consequences that could result in decreased services, access and eligibility for our clients**.**

Specifically, we have significant concern about HHS01 for six primary reasons:

First, if consolidating the three programs means selecting any procedures, requirements, and rules to be applied in all three areas, where today the rules are disparate, there must not be an "averaging" or "leveling down" so that our clients receive less. For example, the income thresholds in Medi-Cal are higher than those in CalWORKs and Food Stamps, the face-to-face requirement is eliminated in Medi-Cal, and the reporting procedures are less stringent in Medi-Cal than in the other two programs. We would oppose any new income level, face-to-face requirement, reporting requirement, or other rule or procedure that streamlines the programs yet results in a cut to eligibility for Medi-Cal recipients' current eligibility levels and procedures (or to Food Stamps or CalWORKs). The risk is that "coordination" will mean using the lowest common denominator or an average, which is a losing proposition for our clients if they lose protections, services, access, or eligibility currently available in any of the three programs in order to achieve coordination.

Second, we reject the premise that the Healthy Families model is suitable for this new amalgamation. As MRMIB, EDS, Maximus, and stakeholders using Healthy Families and Single Point of Entry (SPE) will confirm, the model has shown mixed results with many imperfections and should be analyzed for weaknesses and strengths rather than adopted wholesale. For example, centralization in Healthy Families means applicants has no Eligibility Workers to call, and there are no workers to call applicants and resolve discrepancies or confusion on applications. This results in unnecessary, preventable denials. Given the history of problems of stakeholder access to the Healthy Families eligibility contractor and the fact that Healthy Families is significantly less complex than Medi-Cal, Food Stamps, and CalWORKs, we do not support using the Healthy Families model for any centralization or consolidation of eligibility for the three programs.

Further, while results have been mixed, it is noteworthy that the functions each Healthy Families contractor and MRMIB have performed well are possible in large part because of the relative simplicity of the task – these contractors and the agency are responsible for only one program with relatively uncomplicated rules and procedures. The successes are largely attributable to the agency's and contractors' ability to do only one

thing and perfect it to the extent possible. This would change dramatically if contractors were responsible for three additional and much more complicated programs.

Third, while coordination between programs may eliminate duplication, we are concerned that centralization and privatization of eligibility processing may not result in a better product. Eligibility rules in each program are complex, requiring substantial training to ensure expertise of professional staff of Eligibility Workers in the counties. While the current model is not without its problems, we are not confident that a new, private entity could do better. Centralizing eligibility would eliminate essential case management services and personal attention that EW's can provide, increasing confusion and detachment of recipients.

Fourth, we oppose efforts to privatize in the name of modernization, and appeal to the Administration to parse the two efforts out for careful analysis. While some modernization efforts (such as adding online applications and eliminating paperwork burdens like the assets test) could be beneficial to our clients if done properly, these changes do not necessitate use of a centralized private contractor.

Fifth, we are concerned that a private contractor model will not allow public accountability and transparency. At its best, in our current model, one important mechanism to ensure that public programs run as smoothly as possible is that the users of the program, the advocates, providers, and other stakeholder groups have access to meaningful data and information so we can work with the agencies responsible toward enhanced service and a better functioning program. With a private contractor, we are concerned that this accountability will not be readily available, leading to an unmonitored system under which the vulnerable and needy poor Californians pay the price.

Sixth, the detail in this proposal is extremely limited and does not answer important questions about how the centralized, coordinated eligibility systems will preserve and improve program integrity, access, and transparency. To properly evaluate new models and systems, we need significantly more assurance that the Administration is committed to these goals, with detailed answers about how they will be achieved.

We have several initial questions:

- How will this proposal reduce or eliminate Eligibility Worker functions? How many eligibility workers will be eliminated, which functions will the centralized private entity be responsible for, and what will the counties still be responsible for?

- How will the state ensure program access so that this proposal does not result in any loss of eligibility, services, or access to any of the three benefit programs for anyone currently eligible? Specifically, how will this proposal provide accommodations for the hardest to reach and neediest Californians not able to adapt to new technology and service delivery systems? Would the proposal eliminate or reduce in-person and phone eligibility workers for Medi-Cal recipients who are not recipients of Food Stamps and/or CalWORKs as well as those receiving multiple benefits?

- Will this centralization and coordination occur at application only or for other eligibility functions (reporting, re-determination, case management, service delivery, etc.)? How will the Administration retain sufficient eligibility staff to ensure that counties can perform ongoing case functions?

- Will this consolidation be based on an analysis of program improvements that need to be made to increase access in each program, such as reduction of paperwork burdens and elimination of barriers not required by federal law?

- What public process will be available to ensure stakeholder input in the building and implementation of this new private-public entity?

- What is the Administration's commitment to preserving the most protective (least restrictive) elements of each program, and expanding them to the other two in order to achieve streamlining?

- What changes would be made to the Welfare and Institutions code sections governing Medi-Cal, Food Stamps, and CalWORKs eligibility?

- What mechanisms would be used to ensure public accountability of this private-public entity?

- What timeline would be used to establish and implement this model, and what would the Administration do to ensure enrollment and retention during the transition?

- Given the goal of coordination, efficiency, and improved customer-service, which other eligibility simplification proposals is the Administration willing to consider as part of this coordination effort?

- What is the evidence that a private-public model is effective, efficient, user-friendly, and the best model for the new entity? Has the Administration evaluated other states' experiences, including problems with program integrity and contract fraud or failure? What other models has the Administration considered, and if a new entity is necessary, why is the private-public model the best use of limited public resources?

- How will the Administration amend its proposal in light of analysis of other states' efforts that reveal numerous problems and unanswered questions casting doubt on whether this private model is cost-effective, how to ensure program integrity and access, whether this large-scale change is doable and in what timeframe, and what the state's capacity is if the contractor fails?

A. The Governor should work with the Legislature to centralize and consolidate eligibility processing for Medi-Cal, CalWORKs, and Food Stamps at the state level and to follow the model of California's Healthy Families program utilizing a public-private partnership.

1. Will the proposal improve access to services? Does it make it simpler for customers/clients?

We are deeply concerned that using a private contractor for eligibility functions will decrease access to services and make the process more burdensome for customers who are left without meaningful eligibility worker assistance and must navigate a complex and newly transformed system without meaningful assistance from the Medi-Cal agency.

However, there are several additional ways other than privatization to make the process simpler for recipients that the Administration should explore to eliminate the current duplicative burdens on recipients. This proposal could improve access to services if it adopted new procedures to automatically enroll applicants in all three programs if after one eligibility function, they were deemed eligible. Currently, CalWORKs recipients automatically get Medi-Cal, but not Food Stamps. Food Stamps recipients do not automatically get Medi-Cal. However, California has the federal option to change this. For example, Food Stamps is a more restrictive program with more restrictive eligibility levels and procedures. Some states automatically enroll Food Stamps recipients in Medicaid. This should be explored. Further, other states automatically renew benefits on other public programs when a recipient renews another, eliminating duplicate renewals and excessive administrative costs. California has refused to do this so far, but could save costs by accepting Food Stamps renewals for Medi-Cal recipients, for example. Eliminating duplicative reporting could also make the process simpler and save administrative dollars. This would only improve the programs for our clients if the requirements were "leveled up" to use the least restrictive rules.

2. Will the proposal improve delivery of services?

Likely not. Today, CalWORKs and Food Stamps applicants must apply in the welfare office and some Medi-Cal applicants choose to, and even if they apply through another method they are assigned a worker who can navigate the process with them to ensure successful enrollment. Centralizing and privatizing application processing will remove these functions from the applicant's location. If the Healthy Families model is used, the applicant will not have a worker s/he can call to resolve problems with the application or ask questions. Now that Healthy Families has also eliminated the incentives for Certified Application Assistors, the error rate has sky rocketed. This has resulted in increased administrative overhead and long delays in eligibility. While we would favor removing the face-to-face requirement, we oppose elimination of the EW or the

face-to-face option, which would significantly increase confusion and decrease access and delivery of services.

We are especially concerned about how the harder to serve and neediest low-income Californians will access services under this proposal. A private contractor might not have incentives to spend extra time and effort to enroll these clients with more complex cases, in favor of easier, quicker cases, especially if they are paid in any capped fashion.

3. Will the proposal improve outcomes?

This largely turns on what eligibility rules and procedures are utilized. If the rules are not leveled up to the least restrictive for all three programs, less people will become eligible. This will clearly result in negative outcomes. To the degree that eligibility is established at the least restrictive level and the application process is simplified allowing more persons to enroll, the proposal could improve outcomes.

Also, consider that Los Angeles County attempted a similar consolidation over the last several years using its computer program LEADER, which was designed to coordinate eligibility functions for Medi-Cal, Food Stamps and CalWORKs. Years later, LA County is still struggling to implement narrowed portions of this goal. LEADER has been rife with problems, and routinely sends erroneous denial or termination notices, to the magnitude that LA County has developed a very complex web of "workarounds" (manual functions performed in conjunction with LEADER necessary to reach a result consistent with program rules) which took 2 years to implement and is still not error-free. Due to the complexity of the programs and programming difficulty in ensuring people got all the protections and benefits they were eligible for, LA County had to retreat from the initial goal and separate out the programs just to make sure it could keep Medi-Cal recipients from erroneously losing benefits. Because the Food Stamps and CalWORKs rules are significantly more restrictive and the programming and coordination was so complex, the coordination between programs resulted in wrongful loss of benefits so frequently that LA County had to rethink this goal and pull back significantly in order to perform basic eligibility functions more accurately.

4. What will be the impact on the service provider network?

Unknown. We need more details. How would this proposal eliminate or reduce Eligibility Worker functions?

5. Will the proposal improve program efficiency?

Unclear. There is not enough information available to answer this. We need significant details about which portions of the Healthy Families model will be used, how the three programs' eligibility rules and procedures will be changed, and how much this proposal will cost.

B. The state should adopt a self-certification process for the asset test for applicants other than the aged, blind, and disabled.

To simplify eligibility processing for families, the asset test should use self-certification by the applicant followed by electronic verification of income during eligibility processing. The data and systems exist to ensure accuracy.

1. Will the proposal improve access to services? Does it make it simpler for customers/clients?

We support self-certification of the assets test and believe it will improve access to services and make the process simpler for customers and clients (although we disagree with the exclusion of the aged, blind and disabled, and do support an outright assets waiver, as used in the FPL programs for pregnant women and children). Too many applicants are currently denied because they have difficulty complying with the burdensome paperwork and verification requirements necessary to prove assets. Allowing applicants to self-certify how much they make, what resource they have, and other facts contributing to their eligibility, will save time and resources and help eligible poor people receive Medi-Cal.

For this change to work, self-certification should be allowed at initial application, on required reports, and at annual re-determination.

Also, This proposal is thin on details and does not explain how extensive the self-certification will be. To truly reduce the administrative costs and the burden keeping eligible people off Medi-Cal, self-certification must be allowed for all segments of the application, reporting, and redetermination forms – income, resources, other health coverage, disability, etc., thereby eliminating a need to send any supporting documentation.

2. Will the proposal improve delivery of services?

If self-certification is adopted and implemented to remove verification barriers from the application, reporting, and redetermination processes, the eligibility screen will be a more accurate test in determining actually eligible persons, instead of preventing eligible persons from enrolling and retaining benefits when they have difficulty complying.

For this proposal to improve access, the process including verification of income by the worker must not be in actuality an intensive follow-up in which the applicant or recipient is typically required to provide documentation. The self-certification should mean that most if not nearly all applicants can complete a successful application (or other required form) without being asked for follow-up documentation. It is our experience that when a worker follows up and requests additional information, that is an additional opportunity for the application process to be stalled or fail completely. Eliminating this step will improve access

by using a pure self-certification model except in rare cases. Implementation of this proposal will be important so that the barriers are actually lifted.

3. **Will the proposal improve outcomes?**

   If self-certification helps more eligible people get and keep benefits, this would improve health outcomes.

4. **What will be the impact on the service provider network?**

   Assuming Eligibility Workers are retained, this will save them time and allow them to focus their efforts and energies on helping eligible persons get, keep, and access benefits rather than process unnecessary paperwork. It should not impact other service providers, from the limited details available.

5. **Will the proposal improve program efficiency?**

   Workers will save time and funds when they do not have to process verifications at application, reporting, and re-determination, and could spend more time helping eligible people get, keep, and use services. We will need more details about this proposal to determine efficiency.

C. The State of California should have a public awareness program component for the transition to an Internet-based eligibility system.

Pennsylvania's start up experience with an Internet-based system indicates that a sufficient public awareness program is necessary to accomplish the transition to the transformed eligibility process. The estimated cost of the public awareness and outreach program is $36 million total funds per fiscal year.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   Moving to an Internet-based eligibility system will improve access for the segment of the population that has internet access and finds it easier to use than in-person or by-mail application. However, even in this increasingly computer-savvy time, many low-income Californians do not have ready access to the Internet and cannot rely on it as a primary portal to these public programs. Therefore, the Internet system must not fully replace the mail-in application used in Medi-Cal, or the face-to-face, but merely provide another option. Applicants who feel more comfortable mailing in a document or visiting a website (or using an outstation worker, or numerous other avenues) should be allowed to use those method under the "No Wrong Door" theory that giving applicants multiple ways to access benefits will increase the likelihood that public programs are actually available to a diverse beneficiary population with diverse needs and abilities.

The public awareness campaign could vastly improve access to services if it is crafted in a user-friendly way with significant stakeholder input so that the messages communicated are clear and meaningful.

2. **Will the proposal improve delivery of services?**

   This proposal could improve delivery of services if it results in more eligible persons getting enrolled. See answer above about needing to retain other methods to apply.

3. **Will the proposal improve outcomes?**

   See above.

4. **What will be the impact on the service provider network?**

   Not enough detail available.

5. **Will the proposal improve program efficiency?**

   We would need more detail to answer this question fully. Allowing persons to apply by Internet could reduce administrative costs now expended to process paperwork and verification, and could remove burdens on the applicant. Yet we would like more details about how this Internet-based system would fit into a larger eligibility and service delivery model.

D. The state should pay a one-time application assistance fee of $50 for all four programs to certified application assistants that will enhance community-based assistance with the application process.

In its early years, Healthy Families paid a one-time application assistance fee of $ 50 to Certified Application Assistants for a completed application resulting in enrollment. Since discontinuing this payment more applications have been received that are incomplete.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   We are also concerned that a cut in funding to CAA's and outreach workers has resulted in less applications, not to mention less successful applications because less applicants are assisted (and therefore, they are more likely to make mistakes). We approve of efforts to increase community-based assistance to applicants.

   However, we have concerns about how the CAA's would be trained, and whether they would be able to accurately process applications in all of the public programs. For this proposal to work, the CAA trainings would have to be vastly improved to ensure that CAA's know all of the program intricacies and can

successfully enroll eligible persons. Quality control is extremely important, especially given the complexity of the public programs.

The other problem with the CAA system is the incentive is only to obtain enrollment. If a client has other problems or need help with a different program, the CAA is not available to assist the client.

2. Will the proposal improve delivery of services?

This will depend on how far-reaching the CAA program would be and how successful in reaching otherwise disconnected yet eligible persons. Applicants who are assisted generally file more complete applications and have a higher success rate.

However, the success of this proposal will require the CAA to have an Eligibility Worker processing the application that he/she can troubleshoot with if there are questions or problems with the application. Adoption of the centralized private eligibility model proposed above would reduce the likelihood that CAA's could resolve problems with applications. In our experience in Medi-Cal and Healthy Families, the community based CAAs' jobs are not done when the application is submitted, and the success of the application is largely due to having someone in the county they can communicate with to resolve problems. A centralized processing entity would make this less likely – consider that Healthy Families does not have regular workers available to the public for resolution of problems, and the advocates able to get through only do so because of well-established, hard-earned channels. If any portion of the centralized model is adopted (which we have strong concerns about, see above), this would have to be changed for the CAA's to have any real impact.

3. Will the proposal improve outcomes?

It could if enrollment were maximized, if more community workers are in the community to help identify and enroll eligible persons.

4. What will be the impact on the service provider network?

It would remobilize community workers to get more involved in application assistance.

5. Will the proposal improve program efficiency?

Likely to improve efficiency if CAA's and eligibility workers are able to continue their work together to troubleshoot applications so that eligible persons are enrolled.

E. The state entity responsible for the contract should be authorized in state statute to receive the same contracting authority as is now granted to the California Medical Assistance Commission, the Managed Risk Medical Insurance Board and Medi-Cal managed care contracts.

We have not found that the public-private partnership has been altogether successful, and request more information about how the new contracting authority would work. We do not support privatizing eligibility processing, in part because in other states that have tried this it has resulted in decreased customer service, decreased access to benefits and service, and increased confusion. We also need to see some evidence that this model would in fact be cost-effective. In other states that have developed or implemented private contractor eligibility models, there are serious questions that no states have answered about whether a private contractor can perform functions as well as the government entity, whether they can do so cost-effectively, whether they can preserve and enhance customer service, and whether they can do so in a publicly accountable, transparent way.

We aim to maximize the public funds for these programs, and have serious doubts about whether directing them to a for-profit private entity is efficient, effective, or in the best interests of the low-income Californians the programs are designed to serve. We do not support a proposal that brings a sizable bounty to a private contractor at the expense to California's neediest and most vulnerable residents.

HHS02 Realigning the Administration of Health and Human Services Programs

Amendments to the Welfare and Institutions Code to relieve counties of the responsibility for indigent health care and transfer responsibility for funding and administering the Medically Indigent Adult (MIA) program to the state.

While this proposal as presented appears attractive because it requires the state to assume the entire responsibility for the MIA program, including its funding, this proposal provides little information regarding how the state should amend the Welf. & Instit. Code to accomplish this task or what "single eligibility standard" would be created. While there can be no doubt that the current county indigent health care system and structure is inadequate in both funding and services to meet the demands of serving the population of county residents that are eligible for healthcare, we have serious doubts that shifting the responsibility of providing care to these individuals to the state will in any way increase the services or access to care. In fact, it seems unlikely and that the real motivation for this proposal is, again, to expand contracts with private entities that would administer public benefits programs. The existing county safety-net health care system is essential to provide basic health care to those who have nothing else. Dismantling that safety-net system could prove harmful and even fatal to those who rely on it to stay alive.

The portion of the report's recommendation that suggests MIAs could be covered by the state's Medi-Cal program is an important point that should be further examined more closely. Efforts to expand the populations covered by Medi-Cal would both bring in federal dollars to support the ailing health care safety net, while reducing the financial burden on both counties and the state.

Western Center has several initial questions:

a) How will this shift in responsibility to the state improve client outcomes and increase access for MIAs in need of health care?

b) What specific amendments to the Welf. & Instit. Code would be made?

c) What single eligibility standard would be created?

d) How would the MIA program accountability be consolidated at the State level? What program accountability and control would there be?

e) How would the state contract out MIA care, as proposed in the recommendation?

1. Will the proposal improve access to services? Does it make it simpler for customers/clients?

As stated above, currently, counties act as the safety net to provide coverage to MIAs. If the state intends to assume the responsibility for MIAs this proposal could improve access or makes it simpler for customers/clients to receive needed health care. Whether the state administered program improves access for MIAs depends primarily upon whether the safety net is kept in place. MIAs with no other means of support must continue to be entitled to medical care, as they currently are under the laws governing county health care. There must also be a fair process for deciding applications for assistance and reviewing denials or terminations of aid. If the state intends to seek an expansion of Medi-Cal to include MIAs in order to draw down the federal match, this could be very positive. Again, it depends on how this is done.

2. Will the proposal improve delivery of services?

It seems difficult to imagine how the state would improve the delivery of services by safety-net providers. While additional funding could help expand care available and improve the access to timely care by MIAs, it seems unlikely that the state would increase funding to safety-net providers in order to do so.

3. Will the proposal improve outcomes?

As the preliminary questions above indicate, there is not enough information in the report or recommendation to adequately answer this question.

4. **What will be the impact on the service provider network?**
   Again, as the questions above indicate, it is unclear from the little information in the report how the safety-net provider network would be impacted. Of course the biggest concern would be that the already overtaxed safety-net system would be further strained or dismantled.

5. **Will the proposal improve program efficiency?**

   While some greater efficiency could be realized by centralizing funding and oversight responsibilities with the state, there are too many unanswered questions here to judge whether these potential efficiencies would be outweighed by the reduction in access to care.

HHS10 Align State Law Regarding the $50 Child Support Disregard Payments

The Governor should work with the Legislature to repeal the requirement for the payment of the $50 disregard payment to TANF recipients.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   Reducing the cash available to CalWORKs recipients will reduce their access to services and will not make it simpler.

2. **Will the proposal improve delivery of services?**

   Redirecting funds from recipients to county child support programs may improve the quality of child support administration. However, among the variety of policy options, it is unclear how this compares to other choices.

3. **Will the proposal improve outcomes?**

   Contrary to the conclusion in the CPR report, child support income disregards do increase participation by non-custodial parents. According to a 2002 report of the W-2 Child Support Demonstration Evaluation "[T]he analysis of Office of Child Support Enforcement data repeats the CSDE experimental evaluation finding of a positive relationship between disregard levels and the proportion making some payment in the year. Consistent with the increase in those paying support, the CSDE experimental evaluation found an increase in those receiving child support. Taken as a whole, the results support the conclusion that increasing the pass-through/disregard will increase the payment and the receipt of child support."

   The evidence of enhanced participation is compelling enough to prompt Congress to require such programs in TANF Reauthorization and for the federal government to direct their portion of child support collections to the families as a

way to promote more participation. This proposal will do the opposite and undermine the progress that California has achieved.

4. What will be the impact on the service provider network?

There is no apparent impact on providers.

5. Will the proposal improve program efficiency?

Reducing the amount of money that goes directly from non-custodial parents to the CalWORKs families will likely reduce overall program collections because the parent paying child support will know that the money is not going to the family. The proposal to shift program administration to private contractors, while promoted as a more cost effective method of collection, may result in lower collections and may not result in any state administrative savings.

HHS23 Streamline Oversight Requirements for Conducting Medical Survey/Audits of Health Plans

A. The Governor should work with the Legislature to require the state to use the results from accrediting organizations where they are equivalent to or exceed the state's standards regarding medical surveys/audits of health plans. This legislation should permit health plans voluntarily accredited by approved organizations to be exempted from routine surveys and audits by DHS and DMHC; authorize the state to monitor the procedures of the accrediting organization; and require approval of state officials before accepting the accrediting organization's review in lieu of the state's own review.

1. Will the proposal improve access to services? Does it make it simpler for customers/clients?

Western Center finds the concept of abrogating the state's regulatory authority to a non-governmental entity that depends on the good will of the organizations it alleges to accredit antithetical to protecting the public. Such a proposal is therefore unlikely to improve access to services. It may make it simpler for the plans that are the clients of these accrediting organizations, but we take issue with that as an appropriate goal. It certainly will not make it simpler for purchasers or enrollees as they will not be able to petition elected officials and publicly accountable governmental employees for assistance with problems with their plans. These accrediting organizations are proprietary and operate without public accountability. The voluntary nature as a membership organization creates an inherent conflict of interest, as it is not in their interest to rigorously monitor an HMO that can gather up its marbles and go home if it is unhappy.

We note the only parties consulted outside of government in developing these recommendations were plans and the accrediting agencies. The recommendation

clearly was not intended to be for the benefit of consumers or purchasers and it isn't.

The creation of a separate Department of Managed Health Care with rigorous enforcement and public reporting requirements was a product of widespread unhappiness among consumers. This dissatisfaction was in part due to the difficulty consumers encountered in attempting to resolve problems with their plan. Decentralizing accountability is a significant step backward and will certainly not make things simpler for consumers.

2. Will the proposal improve delivery of services?

We see no way that this proposal could improve the delivery of services to HMO enrollees. It is our view that more scrutiny is needed, not less. If there are standards that are of lesser importance in terms of protecting enrollees or that plans are consistently meeting and exceeding other methods of relieving them of the so-called burden of duplication are possible. Either eliminate requirements or audit less frequently. For instance if a plan routinely meets or exceeds a particular requirement, audit it less frequently or only upon complaint. However, viewing HEDIS ® measures for those plans that make this information public shows that there is still plenty of room for improvement.

Of course we are somewhat handicapped by the fact that we do not have the benefit of the voluminous interviews and other research referred to in the footnotes. We are not surprised nor swayed by the positive comments from other states. It would be unusual for any of them to admit it had been a mistake and equally unlikely that the writers would have included negative comments to footnote a recommendation even if there had been any. Furthermore, the numbers of enrollees in California is so much larger as to defy any comparison. Most of the HMOs in California have more enrollees than the entire population of many of these states. California also has a higher per cent of people with insurance in HMOs than in other states. HMOs must have closer scrutiny because of the closed nature of the network and because of the financial risk they take.

Finally, we are still unconvinced that there is "governmental inefficiency". The mere assertion of such by providers and plans who oppose governmental oversight is not sufficient to wholesale remove this oversight.

3. Will the proposal improve outcomes?

The primary problem with allowing a private, non-governmental outside entity to substitute for state regulation is that it is not accountable to the residents of California. Therefore, it would not be possible to control or even know whether outcomes were improving. If there were signs of trouble, what would we do? How would we even know? The work of these accrediting entities is not public.

Would we have to wait until enrollees start dying or the complaints start climbing?

We also believe that such a disjointed structure would undermine the remaining authority of the regulator. Those large plans that choose outside accreditation would have very little to fear from the state regulator. Presently, when a consumer calls the HMO help center and the staff of the help center contacts the plan, the plan is extremely responsive. After all, this is their regulator. If the larger plans were allowed to defer more to a private accrediting agency they would be far less responsive. There would be little incentive to develop creative, preventive and voluntary solutions to patterns of problems as has been occurring since the inception of the Help Center.

4. What will be the impact on the service provider network?

One aspect of this recommendation is particularly surprising as it appears to be inconsistent with the mantra of this administration. It will have a particularly negative impact on competition. It disadvantages the small and locally controlled, California based non-profit HMOs. The larger national HMOs are the ones who can afford to pay for NCQA accreditation, the smaller non-profits cannot. If the larger ones are allowed to reduce their contribution to make up for the cost of NCQA, a disproportionate financial burden will fall on the smaller HMOs.

The larger HMOs that use NCQA will have less scrutiny than the non-NCQA HMOs. Again, this places a greater burden on the small, locally based HMOs. Many of the small Medi-Cal HMOs plans are heavily dependent on safety net providers and therefore are important to the continued viability of those providers. In some cases there aren't even appropriate NCQA categories for these plans such as the Healthy Families lines of business. For this reason, we think it will only further lead to concentration, less choice and less competition.

5. Will the proposal improve program efficiency?

As stated above, we take issue with the premise that there is demonstrated inefficiency in the program (regulating HMOs). The inefficiency that we see is overlap and consumer confusion between the DMHC and the Department of Insurance, which is not all addressed in this report.

We also believe that the process of trying to figure out which entity is auditing for which standard and who is responsible will result in confusion and inefficiency and more duplication.

B. The Governor should issue an Executive Order requiring DMHC and DHS, or their successor, to eliminate duplicative functions related to conducting medical surveys/ audits of health plans.

1. Will the proposal improve access to services? Does it make it simpler for customers/clients?

This recommendation rewards the bureaucratic unwillingness to be flexible and work in a collaborative way with other agencies. The failure of a pilot project attempt between DHS and DMHC to coordinate audits is used as justification for eliminating the role of DHS.

Western Center views these proposals from the perspective of the Medi-Cal beneficiary, our clients. From this perspective, it seems obvious that the client will not benefit from eliminating DHS oversight of the expenditures of state funds to purchase Medi-Cal services form HMOs.

2. Will the proposal improve delivery of services?

It is incomprehensible that eliminating DHS oversight will improve delivery of services. To begin with there is not as much overlap between DHS and DMHC requirements as this suggests. The DMHC requirements apply to all plans regardless of the line of business. Requiring a plan to meet these requirements ensures that the state is purchasing a product that meets the same minimal requirements as any other plan.

Overlaid on this are the state and federal requirements of the Medicaid/Medi-Cal program. These are not duplicative of Knox-Keene. For instance, Knox-Keene does not require a plan to meet EPSDT standards for children; it does not include chiropractic or nursing home benefits. The medical transportation requirements are not the same. Medi-Cal does require these benefits. There are different due process and notice requirements. How can DMHC assure these? There are standards that are set by contract that are not part of Knox-Keene.

Finally, DHS is a purchaser. DMHC is a regulator. Why would DHS want to abandon its ability to ensure that it is getting its money's worth? How could that possibly improve the delivery of services?

3. Will the proposal improve outcomes?

After many years of false starts, DHS is on the verge of developing an adequate quality improvement program that measures outcomes and works to improve them. It is criminal to abandon that program just as it is about to yield results.

Admittedly, the DHS effort has been less than perfect. It took a few years to find an objective outside contractor to collect quality measures. It has taken a number

of years for DHS to develop audit tools that reflect contract standards and Med-Cal requirements. Completely abandoning this effort to save a few PYS will not only not improve outcomes, but will most certainly cause them to worsen, if they even continued to measured.

4. What will be the impact on the service provider network?

A major emphasis of the Medi-Cal program is the protection of the safety-net. This is of no concern to the DMHC. We think that such a deferral will undermine the safety-net. We also think it will result in a deterioration of the quality of services and providers. Contracting with HMOs is already one level of delegation by DHS that is the single state agency responsible for administration of the program. Accountability will be too much further attenuated if this proposal was enacted.

5. Will the proposal improve program efficiency?

If program efficiency means less staff, less cost and less work than it probably would be more efficient. However, our view is that efficiency means that DHS is getting high quality medical care that meets federal and state requirements. This proposal would prevent DHS from being able to even measure that.

HHS26 MAXIMIZE FEDERAL FUNDING BY SHIFTING MEDI-CAL COSTS TO MEDICARE

The Department of Health Services, or its successor, should authorize EDS to develop an outreach program to enroll Medi-Cal beneficiaries with a diagnosis of End Stage Renal Disease or ALS into the Medicare program and beneficiaries with Muscular Dystrophy or MS into the SSA Title II disability program. This should be authorized by September 2004.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   It appears from a cursory review that this proposal could be beneficial to Medi-Cal beneficiaries. We reserve final judgment until we have additional information.

2. **Will the proposal improve delivery of services?**

   If it functions as described, it could improve access to health care for persons who are dual eligible.

3. **Will the proposal improve outcomes?**
   It may improve outcomes if the described population has access to additional services through the Medicare program

4. **What will be the impact on the service provider network?**
   If it functions as describe, it will increase reimbursement levels for those providers who are Medicare providers

5. **Will the proposal improve program efficiency?**
   The proposal claims to make it easier for people to become eligible for Medicare. This result would be significant program efficiency. It is not clear why the incentive should only be available to EDS and not other entities that assist Medi-Cal beneficiaries become eligible for Medicare. However, if it is such a great idea, it should be more widely available.

A. The Department of Health Services, or its successor, should discontinue the current program notifying Medi-Cal beneficiaries of the benefits of applying for Medicare, and redirect staff performing this function to other activities within the department.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**
   There is insufficient information to comment on this. It is not clear why this piece is necessary to the goal.

2. **Will the proposal improve delivery of services?**
   Not enough information, see above
3. **Will the proposal improve outcomes?**
   Not enough information, see above
4. **What will be the impact on the service provider network?**
   Not enough information, see above
5. **Will the proposal improve program efficiency?**
   Not enough information, see above

B. The Department of Health Services, or its successor, should submit the file of potential Medicare eligibles to SSA to identify the number of qualified work quarters and provide this information to EDS. If a beneficiary is married and the spouse's Social Security Number is on file, DHS should also send a request to SSA for the spouse's work history. This procedure should be implemented by December 2004.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**
   The gist of the proposal to increase the number of Medi-Cal beneficiaries who become eligible for Medicare seems laudable. We do not have enough

information to comment on the specifics. We would note the inquiries required here must be done with consent of the person and respectful of privacy

2. **Will the proposal improve delivery of services?**
   See above
3. **Will the proposal improve outcomes?**
   See above
4. **What will be the impact on the service provider network?**
   See above
5. **Will the proposal improve program efficiency?**
   See above

C. The Department of Health Services, or its successor, should establish metrics to evaluate the effectiveness of this outreach program. The data should be used to determine whether to extend the period in which EDS can share the savings beyond the two-year time frame specified in the contract, whether to staff the outreach program with state staff, or whether to discontinue the outreach program. These metrics should be established by April 2005.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**
   There is only minimal information available to assess this, but we support the concept of evaluation that this seems to be proposing. However, we question why the outreach and incentives should only be open to EDS.

2. **Will the proposal improve delivery of services?**
   See above
3. **Will the proposal improve outcomes?**
   See above
4. **What will be the impact on the service provider network?**
   See above
5. **Will the proposal improve program efficiency?**
   See above

D. The Department of Health Services, or its successor, should determine, by August 2005, whether the Medicare outreach program should be expanded to include other high-cost Medi-Cal beneficiaries.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**
   The outreach program proposed here appears to have positive benefits. There are insufficient details to answer this question.

2. **Will the proposal improve delivery of services?**
   See above
3. **Will the proposal improve outcomes?**
   See above

4. **What will be the impact on the service provider network?**
   See above
5. **Will the proposal improve program efficiency?**
   See above

HHS27 AUTOMATE IDENTIFICATION OF OTHER HEALTH COVERAGE FOR MEDI-CAL BENEFICIARIES

A. The Department of Health Services, or its successor, should develop a process to record OHC electronically.

While the desire to utilize an automated system improve the timeliness and accuracy of information in the MEDS system concerning Medi-Cal beneficiaries with OHC is a laudable goal that we can support, too little detail is provided as to how this recommendation will be implemented, making it difficult to determine how effective a plan this would actually be.

Western Center has several initial questions:

a) What is the basis for believing that the existing contractor, Health Management Systems (HMS) is qualified to effectively undertake the tasks of data matching and automation of OHC on MEDS when DHS has been unable to accomplish such a task after 5 years of analysis of the problem?

b) What is the basis for the assumption that high rates of error will not occur in matching data with carrier and Medicare files?

c) Will any contract with HMS (or any other entity) include performance standards (e.g. that require error rates be under a certain level)?

d) What options will be available for beneficiaries who are negatively impacted by errors in the OHC information that is automated on MEDS?

e) What is the basis for the assumption that 2/3 of the toll-free line staff who trouble-shoot OHC issues for beneficiaries and others will be unnecessary after this automation contract is expanded (especially given the difficulty advocates and beneficiaries currently have in reaching any of those line staff)? What is the current demand for assistance from those DHS staff?

f) Why is the county Medi-Cal eligibility staff unauthorized to enter this OHC information in MEDS currently?

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   Whether or not the proposal will improve access to services for Medi-Cal beneficiaries depends on whether the automated data matches that the contractor relies upon to record the OHC in MEDS is accurate and reliable. Our experience is that there are often errors in the database information that is relied upon to determine whether a beneficiary does or does not, in fact, have OHC. If the information obtained through the monthly data matches with private carrier and Medicare eligibility files is accurate and up to date, and that information is more quickly recorded on MEDS, then access might be improved for those beneficiaries who no longer have OHC. However, if MEDS still incorrectly indicates that they do have OHC, those beneficiaries cannot use their Medi-Cal benefit because of the OHC (the primary payer).

   Whether this automated system will make it simpler for clients is still a question that we cannot answer, as it depends on whether this automated data matching system has a low enough error rate to be reliable. Some beneficiaries who previously were required to contact DHS through the toll-free line to get the information in MEDS corrected may no longer be required to do so if accurate OHC information is more quickly updated in MEDS. It should also be noted that clients have great difficult accessing any help currently utilizing that toll-free line because the workers do not answer those lines or are unavailable.

   Additionally, there are significant problems with OHC that impede access to care in Medi-Cal that this report does not address and that impacts a large number of beneficiaries: Medical Support Orders for Non-custodial parents through the Child Support Agency. Many single or divorced parents on Medi-Cal have OHC provided by the non-custodial parent as a result of a court "Medical Support" order requiring it. Although the OHC is required by the child support order, the custodial parent and child on Medi-Cal cannot access their Medi-Cal coverage because of it and the beneficiary often cannot use the OHC coverage because it is an out of state or out of county insurance plan. In addition, this OHC information gets transmitted from the Child Support Services Division to DHS and is placed on MEDS without the custodial parent being aware of the OHC until their child is denied care under Medi-Cal. Nothing in this proposal will address this major impediment to accessing the necessary care under Medi-Cal.

   Finally, we are unsure why county workers currently do not have the authority to change the field in MEDS re OHC as they have the greatest contact with the client. We believe this option would make it much simpler for beneficiaries to get this incorrect information updated at the local level, would take the pressure off both the DHS toll-free line staff, would expedite the entry of accurate OHC information on MEDS, improve clients' access to the appropriate coverage as well as potentially save money for the state. Also, the fact that the Third Party Liability Branch at DHS has met with a county consortium for over 5 years and

has still been unable to accomplish this automation would argue the point that this issue is much more complicated than the simplistic analysis and recommendations in this report would lead one to conclude. As with most major proposals for change, the "Devil is in the details."

2. Will the proposal improve delivery of services?

This proposal would have a greater impact on access to care than delivery of services, as the primary issue from a client's perspective is access to Medi-Cal health coverage altogether, rather than the specific delivery of services. Clearly under this proposal, access directly impacts the actual delivery of services.

3. Will the proposal improve outcomes?

While it is unclear from this question how the CPR is defining "outcomes," if we define improved outcomes as "more timely access to medically necessary care" then the results depend entirely on whether the OHC data maintained on MEDS is improved in its accuracy (and more quickly).

4. What will be the impact on the service provider network?

From the information provided, it does not appear that this proposal would have a significant impact, one way or the other, on the service provider network that serves Medi-Cal beneficiaries. However, given the little information about implementation of the proposal, it is impossible to accurately predict, at this point, what any possible impact would be.

5. Will the proposal improve program efficiency?

It appears that the purpose of the proposal is to improve efficiency as well as achieve substantial savings for the state. However, as described above, it is still unclear what the integrity issues concerning data accuracy are, and there are also a number of questions about this proposal that would need to be answered. It will not eliminate the need for troubleshooting problems or eliminate all OHC issues, as the discussion in Question #1 explains.

B. The Department of Health Services, or its successor, should initiate a process to disenroll Medi-Cal managed care beneficiaries who have OHC.

While we support the goal of disenrolling, when appropriate, beneficiaries from Medi-Cal managed care plans when they have OHC through a private HMO (as provided for in the state regulations); there are a number of issues that arise which must be considered prior to taking such action. This proposal states nothing about what process should be put in place to disenroll beneficiaries, only that a process should be initiated by DHS. In addition, the report does not mention the fact that there are exceptions to the rule that the beneficiary, in Two-Plan Model counties,

cannot be enrolled in both Medi-Cal managed care and a private HMO plan at the same time (*see* 22 CCR Section 53845(f)). Finally, the report fails to mention the fact that there are regulations that specifically address the disenrollment process available to beneficiaries who qualify (*see* 22 CCR Section 53889).

This report and recommendation over-simplifies the issues by stating in the report that DHS has simply failed to turn on a "switch" in MEDS to automatically disenroll these individuals. The report does not address or mention any of the issues raised above, especially concerns about the integrity of the data that they are relying on to make a decision to disenroll the beneficiary (*see* Recommendation A). Many of the same issues or questions presented by the recommendation above are also present here because an automated disenrollment system would rely on the information about OHC that is entered into MEDS through whatever mechanism devised. Those same concerns and questions will not be repeated here but there are additional concerns and questions that specifically pertain to this recommendation and are discussed I in the questions presented by the Agency survey below.

Western Center has a number of initial questions:

a) How will the automated process to disenroll beneficiaries verify that the beneficiary does, in fact, have OHC prior to terminating them from a Medi-Cal managed care plan to ensure that this is appropriate?

b) How will the automated process account for those beneficiaries with OHC who have no access to the OHC because of non-custodial parent custody order issues?

c) How will automated disenrollment address the continuity of care issues that arise if a beneficiary is undergoing care or treatment from a Medi-Cal plan provider and is disenrolled during that process?

d) How will DHS address the situations where disenrollment is inappropriate due to incorrect information relied upon in data matches or exceptions allowed for in the regulations? Would the beneficiary be required to reenroll?

1. Will the proposal improve access to services? Does it make it simpler for customers/clients?

Whether or not the proposal will improve access to care depends upon the situation of the particular beneficiary and whether or not the integrity of the data relied upon to disenroll the person is accurate. As raised above, if the beneficiary is disenrolled from Medi-Cal managed care due to the incorrect information that the person has OHC, then the person could lose access to their existing plan health care provider or could end up without care in the middle of treatment, both of which would disrupt continuity of care for the beneficiary and may even result in an inappropriate denial of medically necessary treatment. It is not uncommon

for advocates to see instances where OHC information about a beneficiary is incorrectly transmitted due to confusion of plan data regarding a similar/same name or date of birth. If the person is "automatically" disenrolled during a monthly data reconciliation process, they could lose their coverage and lose access to care. There are also instances where this proposal would improve access and beneficiaries would benefit from disenrollment into fee-for-service Medi-Cal because they cannot get access to specialty care or other services not covered by their OHC plan and cannot then use a Medi-Cal plan as "wraparound" coverage.

While in some cases this automated process may make it simpler for a beneficiary who is trying to get disenrolled (due to OHC in an HMO) more quickly, it appears those benefits may be outweighed by possible concerns about inappropriate disenrollment, which might have more devastating and immediate consequences related to denial of care. This report and recommendation does not address those problems or concerns.

2. **Will the proposal improve delivery of services?**

   Generally speaking, the proposal will likely have very little impact on the delivery of services to beneficiaries, except in those instances (described above) where a beneficiary needs access to a specialist or services not covered by the OHC health plan and the beneficiary would benefit from being placed in fee-for service Medi-Cal. However, if the beneficiary is inappropriately disenrolled, it could alternatively result in a denial of care.

3. **Will the proposal improve outcomes?**
   As described in the answers above, while it is unclear from this question how the report is defining "outcomes," if we define improved outcomes as "more timely access to medically necessary care" then the results depend entirely on whether beneficiary in appropriately disenrolled from the Medi-Cal managed care plan.

4. **What will be the impact on the service provider network?**
   From the information provided, it does not appear that this proposal would have a significant impact, one way or the other, on the service provider network that serves Medi-Cal beneficiaries, but, given the little information about implementation of the proposal, it is impossible to accurately predict, at this point, what any possible impact would be.

5. **Will the proposal improve program efficiency?**
   As with recommendation A, it appears that the purpose of the proposal is to improve efficiency as well as achieve substantial savings for the state. However, as described above, it is still unclear what the integrity issues concerning data accuracy are, and there are also a number of questions about this proposal that would need to be answered.

HHS30 CENTRALIZE MEDI-CAL TREATMENT AUTHORIZATION PROCESS

A. The Department of Health Services, or its successor, should centralize treatment authorization request (TARs) field office operations.

While we agree with the goals of improving communication among field office staff and promoting greater consistency on TAR decisions by Medi-Cal, centralization of TARs processing into one single location would not simplify the often complex and lengthy prior authorization requirements that exists for many medically necessary Medi-Cal covered services. The report does not consider other cost saving ideas and efficiencies that could be implemented for the treatment authorization process that would reduce the need for so many TARs in the first place.

In addition, centralization of the TAR offices alone will not necessarily promote greater consistency of decision-making on TARS or encourage reviewers to follow the legal standards for "medical necessity" set forth in state and federal laws and regulations. Also, specialized field offices may offer some advantages because certain expertise may exists in these local offices that would allow for TARS to be reviewed by experts in the specialty areas of the medical services requested. Finally, it may be easier for advocates and medical professionals to access and have contact and better communication with field office personnel and medical experts within the Department who handle a particular type of TAR service, like pharmacy services. Centralization will make that more difficult.

Western Center has a number of initial questions:

a) What other options or quality control measures, aside from TAR centralization, were considered as a cost saving measures (e.g. reducing the types of services requiring TAR approval and instead utilizing other quality controls)?

b) What will happen to the special medical expertise that exists in field offices currently and is available for medical providers or advocates to consult with on cases?

c) What were the data results of the pilot project on TAR approval or denial rates and what, if any, problems were encountered in the pilot?

d) Has the SURGE system (e-TARs) resulted in lower approval or greater denial rates of TARs and has it encountered any problems? How do providers access DHS personnel to discuss particular decisions on TARs?

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

It is difficult to say whether this centralization will improve access without more information on the pilot project results and providers experience with the e-TARs system. Many of the questions and comments above address the possible concerns. In addition, if the centralization results in lower approval rates or consistency of TARs equates with stricter review of TARs, then it may in fact impede access to services. Nothing in this proposal will make it simpler for the client but perhaps providers will have to be the ultimate jurors regarding of its probability of success.

2. Will the proposal improve delivery of services?

It will only improve access if centralization results in more appropriate, as well as consistent, TAR decisions and the TARs are approved more quickly and efficiently. It is difficult to tell if that will be the result.

3. Will the proposal improve outcomes?

The answer to this question is again difficult to access given the limited information available in the report. As with the prior question, it will only improve access if centralization results in more appropriate, as well as consistent, TAR decisions and the TARs are approved more quickly and efficiently.

4. What will be the impact on the service provider network?

It is entirely unclear, given the information available in the report. If the provider believed it was an improvement, perhaps more providers would become take Medi-Cal. If the experience were negative, more providers would stop taking Medi-Cal.

5. Will the proposal improve program efficiency?

Again, while the result may indeed be greater efficiency of staff and resources, the cost benefit analysis depends greatly on whether these do in fact increase more timely access to care.

B. The Department of Health Services, or its successor, should ensure adequate resources are devoted to automating the TAR process as scheduled for July 2005.

While automation of the TAR process should, in theory, improve customer service by enhancing timeliness of TAR receipt/approval and reimbursement to providers, whether that will in fact occur depends greatly on whether that process is perceived by providers as an improvement. In addition, any time you automate a s system, it

results in greater rigidity in how information is accepted and in what form. This report does not address the questions of how the automation of TARs will still allow for the inclusion of individualized information. As stated above, more information is needed regarding the pilot project and the SURGE system to assess its veracity.

Western Center has a number of initial questions:

a) Will the automation allow for the inclusion of individualized information not contemplated on a single form?

b) How will an automated system account for the need for personal contact with the Department to address particular concerns or questions about a beneficiary or TAR?

c) What were the lessons learned or problems encountered in the pilot project or the e-TAR system regarding improving access to care or the TAR approval rate?

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   In theory it should improve the timeliness for TARs consideration however whether access to Care will be improved or not depends on the experience of providers, as described above.

2. **Will the proposal improve delivery of services?**

   The answer to this again depends upon whether it results in an increase in timely TAR approvals. There is not enough information in the report to fully access this question.

3. **Will the proposal improve outcomes?**

   See above.

4. **What will be the impact on the service provider network?**

   It is unclear, given the information available in the report. If the providers believe it is an improvement, perhaps more providers would accept Medi-Cal. If the experience were negative, more providers would stop taking Medi-Cal.

5. **Will the proposal improve program efficiency?**

   While in theory it should, as it is designed to save money and be more efficient, whether it will be perceived by the providers and clients as an improvement is unclear from the report and the little information provided. It is unclear from this report how the automation will be implemented.

C. The Department of Health Services, or its successor, should adopt telecommuting procedures for medical case management nurses currently located in TAR field offices.

While this proposal makes sense on its face, nothing in the report describes how the office space is currently used by the case management nursing staff or whether telecommuting and using web-based medical reviews would be problematic or unworkable. More information is needed to access this proposal more thoroughly.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   There is little in the report to adequately access this question. The proposal appears to have little effect on improving access unless the result would be greater time spent with clients in the field.

2. **Will the proposal improve delivery of services?**
   See above.

3. **Will the proposal improve outcomes?**

   See above.

4. **What will be the impact on the service provider network?**
   It appears to be minimal, if at all.

5. **Will the proposal improve program efficiency?**

   The intent is clearly driven by efficiencies in the form of cost savings to the Department. The drawbacks, if any are unclear or not discussed.

HHS33 ELIMINATE DUAL CAPITATION FOR MEDICARE/ MEDI-CAL MANAGED CARE PLANS

A. The DHS, or its successor, should either modify the health plan contract language to state that DHS will terminate the capitation if a beneficiary client has certain types of health insurance, including enrollment in a Medicare managed care plan, or develop a blended rate for beneficiaries that are dually capitated, so that the Medi-Cal rate only reflects payment for services not covered by the Medicare program.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   This is unlikely to improve access for Medi-Cal/Medicare beneficiaries, but it may save money without any negative impact. There is insufficient information to determine this.

2. **Will the proposal improve delivery of services?**

   It will probably not improve the delivery of services.

3. **Will the proposal improve outcomes?**

   It seems unlikely to improve outcomes.

4. **What will be the impact on the service provider network?**

   There is inadequate information, so it is not possible to determine whether the provider network will find it easier or more difficult to obtain reimbursement due to this proposal

5. **Will the proposal improve program efficiency?**

   It is not possible to assess this.

B. The DHS, or its successor, should notify the Health Care Options vendor that the state wishes to enforce the existing contract provisions regarding disenrollment because of other health insurance.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   Enforcing existing contract provisions is usually a good thing. It is difficult to use this format to comment on this any further.

2. **Will the proposal improve delivery of services?**

   See above

3. **Will the proposal improve outcomes?**

   See above

4. **What will be the impact on the service provider network?**

   See above

5. **Will the proposal improve program efficiency?**

   See above

C. The DHS, or its successor, should make all necessary programming changes to reflect the policy change in recommendation A. Some of the associated programming changes have already been coded, but were never installed.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   See answers to B and C above

2. **Will the proposal improve delivery of services?**

   See answers to B and C above

3. **Will the proposal improve outcomes?**

   See answers to B and C above

4. **What will be the impact on the service provider network?**

   See answers to B and C above

5. **Will the proposal improve program efficiency?**

   See answers to B and C above

D. The DHS, or its successor, should review and analyze the policy to permit County Organized Health System (COHS) beneficiaries to also be enrolled in Medicare health plans. The analysis should determine whether it is more cost-effective to provide those health care services not covered by Medicare through a fee-for-service arrangement with the COHS plans or other local providers.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   It is not possible to determine a response to this based on the information here. One note of caution is the unavailability of fee for service providers in COHS counties. It is also possible that some beneficiaries would have access problems if they can't join a Medi-Cal managed care plan. Western Center on Law and Poverty would like more information about the objections of unnamed "client advocacy groups" referred to in the report.

2. **Will the proposal improve delivery of services?**

   See above

3. **Will the proposal improve outcomes?**

   See above

4. **What will be the impact on the service provider network?**

   See above

5. **Will the proposal improve program efficiency?**

   See above

E. If the DHS decision is to continue the existing policy of allowing COHS beneficiaries to be concurrently enrolled in Medicare managed plans, then DHS, or its successor, should make programming changes to provide the COHS plans with a list of their beneficiaries who have other health insurance, including Medicare HMO coverage.

1. **Will the proposal improve access to services? Does it make it simpler for customers/clients?**

   There is insufficient information here to answer this question. It depends on how this was implemented and what impact it would have on access

2. **Will the proposal improve delivery of services?**

   See above

3. **Will the proposal improve outcomes?**

   See above

4. **What will be the impact on the service provider network?**

   See above

5. **Will the proposal improve program efficiency?**

   See above